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COUNCIL BRIEFS

Physicians to retain PSRO initiative beyond Jan. 1, despite 'deadline' in law

For the foreseeable future, the government will avoid looking to nonphysician groups as organizers of PSROs after the Jan. 1, 1976 deadline passes, the National PSR Council was told last month.

Because funds to gear up a vigorous program are lacking, the Bureau of Quality Assurance has recommended, in effect, an administrative extension of that statutory deadline.

Dennis Siebert, acting director of program operations, says he knows of no activity from nonphysician groups in unfunded PSRO areas, thus the question of nonphysician PSROs is not an issue. There are, he said, only five states without PSRO activity now.

PLANNING PSROs EXTENDED

In addition, BQA reported that the current planning PSROs will continue with budget extensions into 1976, with the question of which ones to convert to conditional left unanswered until that agency comes up with criteria for choosing the future conditionals.

Up until the Jan. 1 cutoff, the law requires the government to determine--

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Health systems agencies and PSROs: Will they be friends or foes?

CHICAGO--The question of whether PSROs and Health Systems Agencies (HSAs) are to be friends or foes was raised in a panel session at the recent annual meeting of the American Public Health Association in Chicago. The consensus among the panelists was that no inherent conflicts exist as far as the legislative intent of the PSRO and health planning laws, but that disagreements may surface as the laws are further implemented.

Proposed regulations published in the Oct. 17 Federal Register include a PSRO coordination section that states that each HSA must attempt to negotiate a written agreement with each PSRO whose area is in whole or in part in the agency's health-service area.

THE KEY ITEMS

Robert W. Crane, chief, technical assistance branch, Bureau of Health Planning and Resource Development, DHEW, described the items to be included in the agreement:

*Development of a common data base and exchange of data;

*A provision for review and comment by the PSRO on the HSA's health systems and annual implementation plans, especially regarding quality of care, utilization of services, and needs for new resources;

*A provision of technical assistance to the PSRO by the HSA;

*A provision of assurance that whatever actions taken by a PSRO will be consistent with the health service plan for that area.

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Nurses look to PSRO as a challenge and an opportunity

Strengthened by a sense of their own growing professionalism, most nurses appear to be looking ahead to peer review under the PSRO program confidently, seeing in the program's requirements for documentation an opportunity to upgrade further their profession and to demonstrate on paper the importance of nursing care to the overall care of the patient.

WORKING TOWARD PARTICIPATION

At the same time, while publicly downplaying any concern nurses may have about their exclusion from PSRO membership, nursing groups are working quietly to assure the highest possible level of participation by their profession in PSRO activities.

These were some impressions gained by PSRO Update in telephone conversations with nurses, nursing administrators, professors of nursing and spokespersons for professional nursing associations in recent weeks.

Meanwhile, the American Nurses' Association presented its draft manual "Guidelines for Review of Nursing Care at the Local Level" to the National Professional Standards Review Council at its meeting Nov. 18 and was asked to resubmit the document in January after making minor revisions aimed at clarification.

One of two documents produced so far under a $250,000 contract with the Bureau of Quality Assurance of DHEW, the manual is described by Geraldine Ellis, nurse adviser in the division of peer review of the BQA, as a "practical, how-to guide" to help nurses develop quality assurance programs in their own areas. After its approval by the National Council as a technical assistance document in January, "Guidelines" will be distributed to all short-stay hospitals and state nurses' associations.

SCREENING CRITERIA

Besides directions for setting up a quality assurance program in nursing, the manual includes directions for developing audit criteria, and 16 sample sets of screening criteria to be used as models for nursing audits or medical-care evaluations. The guidelines focus on outcome criteria, Ellis said.

"Only 16 sample sets of criteria were included, because the ANA and the nurses who worked on the guidelines feel strongly that criteria need to be developed at the local level to reflect local standards of practice," she explained.

The second document produced by the ANA under its contract with BQA is titled "Recommendations for Involvement of Nurses in PSRO Review Process." Intended as an aid to the senior staff of the BQA, the "Recommendations" have been submitted to that group and are currently "under consideration," according to the BQA.

For the most part, nurses interviewed emphasized the positive aspects of PSRO for nursing. "PSRO is going to force us to put it in writing--especially the assessment of the patient's nursing needs, and the nursing interventions required to meet them," said Ann McCourt, R.N. of the Massachusetts Nurses' Association.

DOCUMENTING THE EFFECT

Betty Erlandson, R.N., director of the ANA's PSRO project for the contract with BQA, said, "We have to be ready to document that nursing made a difference in the outcome of this patient."

Muriel Poulin, R.N., professor and coordinator of the program in nursing administration at Boston University School of Nursing, added, "PSRO legislation has made us take a new look at accountability and especially at how we are going to tangibly demonstrate accountability."

"I consider PSRO very positive for nursing," said McCourt, "but the degree of positiveness depends on whether we can get nurses on policy-making boards....Nursing is going to have to control the nursing aspects of care," she added.

The PSRO law restricts membership in PSROs to doctor of medicine and of osteopathy. Nowhere in the law are nurses referred to as such; instead they are lumped together with others under the term "nonphysician health practitioner."

ROLE OF NONPHYSICIAN

Under the law, nonphysician health practitioners are "expected" to participate in developing norms, criteria and standards for their areas of practice; developing review mechanisms for peer assessment of the performance of nonphysician health practitioners; and conducting health-care review of nonphysician health-care practitioners by their peers. Where care is provided jointly by physicians and nonphysician health-care practitioners, the latter would participate in joint development of criteria and joint assessment of care by peer physician practitioners.

In testimony to the health subcommittee of the House Ways and Means Committee in September, representatives of the ANA pro-

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Progress Notes from the Northeast

New York

PSRO officials concerned about possibility Gov. Carey may slash hospital-audit funds

PSRO officials in New York City and other cities in the state are deeply concerned about the possibility that Gov. Hugh Carey, in his budget message expected soon, will recommend sharp slashes in funds now provided to the State Department of Social Service to do hospital audits under the Medicaid program.

PSRO officials have already learned via the grapevine in New York State Health Department circles that such slashes are definitely expected to be listed in the budget message.

PROBLEM FOR THE PSROs

Speculation in PSRO circles is that if such cuts go through, the auditing problem will be thrust upon the PSROs. This would confront the PSROs with a severe problem--the lack of funds to take over such an additional responsibility.

As one PSRO official remarked, "The state can then say that it doesn't have money to audit the nursing-home program and the outpatient program, and toss the problem to the PSROs. And we don't have the money to handle it." It would then be necessary to appeal to DHEW for additional funds for the added burden, he added.

(Currently, the task of auditing the Medicaid program in the state has been handled by the state Health Department for the state Department of Social Services.)

The problem is doubly compounded in New York City,where there are 18 remaining municipal hospitals with their traditional deficits. (One of the original 19 was closed some time ago.) There has been strong pressure on the Health and Hospitals Corporation, which operates the municipal hospital system, to close some of its hospitals. This pressure has intensified during the city's fiscal crisis.

The closing proposal has been strongly resisted by both community and ethnic groups, for whom the city hospitals represent not only medical care but also jobs for minority groups.

NO DELEGATION FUNDS

For the PSRO, the municipal hospitals present a special problem for delegation of hospital review. The hospitals have no funds for this purpose, and the New York County Health Services Review Organization, whose executive director is Eleanore Rothenberg, has been exploring ways in which this problem could be solved.

Rothenberg told PSRO Update that the PSRO would be willing to handle hospital utilization review (UR) to "relieve the burden" on some municipal hospitals, but it has "only a small amount of money for this purpose." She said the possibility of this is "very preliminary" at present, and further discussion with the Health and Hospital Corporation is necessary.

A study last month by the New York Times pointed out that the 18-hospital system gives medical services for more than two million patients a year, most of whom are poor, aged or both. In addition, the municipal system handles nine out of 10 emergency cases in the city, half of all outpatient care, and a quarter of the inpatient care. It costs $1 billion a year to run.

Morton N. Chalef, director of the PSRO state wide support center, suggested that closing the city hospitals would further complicate the UR problems of the voluntary hospitals. "The voluntaries would need more people to handle the utilization-review committees, and that would mean more money would be needed," he said. ■

Statewide data-bank plan advances; officers named, planning grant proposed

Plans for a statewide data bank in New York have now advanced to a point where officials of a recently formed study group, presently incorporated as a nonprofit organization, have requested $180,000 from DHEW for a one-year planning grant.

The original discussions bogged down over a question of representation of the

four groups concerned (PSROs, the hospitals, Blue Cross and other private intermediaries, and the state Health Department). Then it was agreed to give equal representation in the new group to all four groups. After this accord was reached, it was agreed to establish a study group to examine the feasibility of a statewide data consortium.

FORMALLY ORGANIZED

The new organization is called the New York State Study for Unified Hospital Data System, Inc. "We are now formally incorporated and have elected a provisional board of directors and executive committee," David Pomerinse, M.D., executive vice-president of Mt. Sinai Hospital, and chairman of the board of directors of the new group, told PSRO Update. "We have asked $180,000 for a planning grant for the first year, and eventually would become a self-supporting organization by charging for the service."

Pomerinse feels that "there's something in it for everyone" in a statewide data bank. He also feels that the debate about representation, with its implications about who would control the organization, "is now behind us."

Among matters being discussed are data confidentiality and the "cheapest way to handle the transmission of data." Pomerinse noted that "we might possibly subcontract with an outside agency to process and monitor the tapes."

Roger C. Herdman, M.D., deputy commissioner for research and medical care, New York State Health Department, and secretary of the study group, told PSRO Update that the bylaws are "just about in final form."

KEY ISSUES ADDRESSED

Key questions include avoidance of duplication and that of confidentiality, Herdman said. He pointed out that the usage of Social Security numbers for physician identification, for example, is "a matter of legitimate concern." Another question being studied is "the way the data are gathered."

This involves "where the data would go first, to the payer or the consortium, for example," Herdman said. He added that at forthcoming meetings of the group in December, technical subcommittees would be chosen to work on uniform abstracts. He also said that in discussions held by the study group's representatives with DHEW officials, the government had indicated it desires a contract proposal to lead to a series of steps "that would get the idea going, rather than just a feasibility study."

Meanwhile, steps have been taken by the statewide PSRO support center to explore existing data systems for possible application to meet immediate data needs of the nine conditional PSROs. There have been discussions with the Dikewood Corporation, Medical Advances Institute, American Health Systems, Commission on Hospital and Professional Activities, and similar organizations.

■

Health panelists cite need to curb program duplication

The need to avoid costly duplication in New York hospitals was stressed by speakers at recent hearings on health, sponsored by the City Club of New York.

Peter Rogatz, M.D., senior vice-president, Blue Cross and Blue Shield of Greater New York, cited as an example the fact that 28 hospitals were performing open-heart surgery in the New York metropolitan area until recently.

NOT LIKE BUYING CAR

The patient "has no way of judging his need for open-heart surgery," as he would the purchase of an automobile or other items, Rogatz said. "He is totally dependent upon the judgment of his doctors. Thus, we face the phenomenon of a large number of hospitals, each maintaining its own open-heart surgery program, and each...seeking to build its volume without necessarily having as its exclusive concern the best interest of each patient..."

Noting that a minimum volume of 200 cases annually was recommended recently for effective functioning of an open-heart surgery program, Rogatz said that out of a total of 28 programs in existence in 1971, "only five were performing 200 or more open-heart operations annually; two others were reasonably close to that level."

He pointed out that 21 of the 28 programs were performing fewer than 100 cases annually, and that 13 of these were performing fewer than 50 cases annually.

The number of open-heart surgery programs has now been reduced "significantly," Rogatz noted. A similar situation existed in kidney transplantation, with 17 hospitals seeking to develop transplant capability, while the need could be satisfied by "a properly organized network of six transplant programs," he said. He added that Blue Cross and Blue Shield of Greater New York took the lead in organizing a regional conference aimed at discouraging the development of unnecessary programs.

Another speaker hitting duplication

was Martin S. Begun, associate dean of the New York University School of Medicine.

"Obviously, there are those who feel that every hospital--public, private or voluntary--should have a full-range facility," he said. "But this is precisely what drives the costs out of range. The capacity of the consumer to absorb these costs is close to, or at,its limit..." ■

Bronx Foundation first in N.Y. to delegate review to hospitals

The Bronx Medical Services Foundation was the first to have hospitals delegated in New York State. According to Harry Feder, executive director, Parkchester, Misericordia, Union and Mount Eden Hospitals have been delegated for utilization review. Feder hopes to have all 17 hospitals in the Bronx delegated by March.

Feder said his PSRO was the only one in the state at present to have Memoranda of Understanding (MOU) with all parties.

SOME UR FUNDS ON HAND

As for the municipal hospitals in the Bronx, Feder said his PSRO is prepared to pick up part of the cost of operating utilization-review committees if funds are not available from the Health and Hospitals Corporation. "We have $110,000 in our budget for nondelegated hospitals," he pointed out. "In the Bronx, the municipal hospitals are Lincoln, Morrisania, Fordham and Bronx Municipal."

Meanwhile, Area 9 PSRO of New York State, Inc. has a target for delegating five hospitals in December, according to Michael Maffucci, executive director. There are 17 hospitals in the area, and there have been on-site visits to nine. ■

N.Y. has 9 conditionals, 4 in planning stage and 4 areas with no PSRO yet

Nine New York PSRO areas are now functioning with conditional contracts, while four areas still fall in the planning stage, and four other areas haven't reached the planning stage, according to Morton N. Chalef, director of the statewide support center.

Those with conditional contracts include Areas 1 (Buffalo), 2 (Rochester), 5 (Adirondack), 9 (Westchester), 10 (Rockland), 11 (Manhattan),13 (Kings County), 15 (Nassau) and 17 (Bronx).

Those in the planning category are Areas 3 (Syracuse), 4 (Utica), 12 (Staten Island), and 14 (Queens).

Areas 6 (Schenectady), 7 (Albany), 8 (Poughkeepsie) and 16 (Suffolk) have no PSROs yet. ■

New England

AMA criteria sets in use

Most PSROs in New England will be starting review using the American Medical Association's sets of screening criteria, waiting to see how they work and modifying them as needed.

One prominent exception is Bay State PSRO in Boston, which has developed its own short, level-of-care criteria.

Among the PSROs that have modified the AMA sets are the Rhode Island group, where about 140 physicians were involved in the task, and Western Massachusetts PSRO. ■

Northeast PSROs to gather

The Northeast Conference of PSROs, will meet Jan. 14 at the New England Center for Continuing Education in Durham, New Hampshire. Timed to follow directly the next National PSR Council meeting, the gathering is being organized by the Connecticut and Massachusetts Support Centers.

The conference will seek to air the standing issues of federal management of the PSRO program. Organizers hope to enlist the attention of several legislators, bureaucrats, National Council members and critics of the PSRO program. ■

Conditionals face data-bid issue

Time is moving closer for all 11 conditional PSROs in New England to send out their requests for proposal for bids by data processing contractors. Although a number of technical questions remain to be answered by the government, one of the biggest issues continues to be the role of Blue Cross in data processing.

Many PSROs see a clear danger in having the fiscal intermediary as the processor (PSRO Update, Sept., Oct., Nov.), yet government procurement regulations clearly allow Blue Cross to bid, and Blue Cross is clearly interested. ■

RESPONSE APPRECIATED

PSRO Update thanks the readers who responded to the survey that was conducted during September for taking the time to tell us of their interest in the subjects covered in this newsletter.

Health systems agencies and PSROs: Will they be friends or foes?

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HSA-PSRO agreements, according to the proposal, are to be negotiated within six months after the full designation of an HSA. If no agreement can be reached by that time, an explanation for the failure must be sent to the Secretary of DHEW.

TRANSLATING THE DATA

Crane said that the data generated by PSROs can be translated into selected aggregate statistics, which will be necessary for HSAs to establish relative needs and priorities for area programs, as well as to provide a means to study and design actions to correct deficiencies in services.

William B. Munier, M.D., acting director, Office of Professional Standards Review, DHEW, said that relationships between PSROs and HSAs are all very speculative at this time, but that it is foreseeable that some overlap in responsibilities may occur, and therefore disagreements may arise. An example he mentioned would be the PSRO's determining local criteria for care that the HSA sees as having an effect on a wider area, or the HSA's making decisions that affect quality of care.

Munier also mentioned the problem of congruence between PSRO and health-service areas. In only 19 per cent of the 203 PSRO areas is there complete congruity or identity with HSAs. As it now stands, 117 PSROs will have to deal with one HSA; 53 PSROs will have to deal with two HSAs; and 38 PSROs will have to deal with three or more HSAs. To achieve maximum success in programs of planning and quality assurance, Munier believes, both programs must, over time, think about redesignation to bring both programs into congruence.

EASIER SAID?

Redesignation may be easier said than done, according to Michael L. Parker, L.L.B., adjunct associate professor, Health Policy Program, University of California School of Medicine. The problem, he noted, could be that two PSROs in any one HSA may be very different in their nature.

One basic difference that Parker sees between the PSRO and HSA programs is the emphasis planners place on community needs and the physician's emphasis on individual patient needs. Overriding this issue is the question of whether the state of the art for both quality assurance and planning has developed sufficiently to determine credibility of their processes.

Other potential problems mentioned by Parker include the exchange of data without violating confidentiality rules; the differences between lay and professional orientation as it relates to resource allocation; the manner by which physicians view the two programs as competitive with their own practice of medicine; and the constraints the government is placing on the funding of either program.

To resolve some of the basic difference between PSROs and HSAs, Parker said, good sense and good must prevail. ■

Physicians to retain initiative

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through notification and polling of physicians in a PSRO area--whether the group seeking to be designated as a PSRO actually is representative of the physicians in that area. After Jan. 1 the representativeness of the physicians does not matter, according to the law, because the government is permitted to recognize any group it chooses.

Physician-certification policy reversed

A rare instance of satisfaction all around emerged at the National Council meeting, with the announcement by legal counsel of a reverse in policy on physician certification to say that: physician certification of a patient's continued stay did not require a separate notation, but could be inferred from the physician's notes.

The turnabout on policy resulted from the outrage expressed by PSROs in many sections of the country after the announcement in September of the earlier policy. BQA had urged this interpretation of the law, but to no avail until the letters started arriving from the PSROs, according to Larry Sobel of program development.

No 'national' screening standards

Reiterating an earlier position, the National Council made clear its aversion to national standards for admission screening.

In commenting on the draft letter prepared by the BQA to guide PSROs on use of the AMA screening criteria sets, the Council saw the AMA book as a valuable technical tool, but not the final word on criteria.

The BQA asked for the Council's suggestions on how to evaluate the criteria developed by each PSRO--that is, what to include in writing the "criteria for criteria." ■

INDEX COMING

Subscribers will receive, with their January copy of this newsletter, an Index to PSRO Update issue numbers six through 15.

Nurses look to PSRO as a challenge and an opportunity

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posed that PL 92-603 be amended to include registered nurses and other licensed health-care practitioners as members of PSROs. They also proposed other changes to broaden PSRO participation of nonphysician health professionals.

In addition to changes in the law, McCourt would like to see every reference in PSRO regulations to "medical care"--generally understood to refer to the care given by physicians--changed to "health care," a more inclusive term.

"You cannot isolate the patient with the doctor," McCourt explained. "The doctor does diagnosis and treatment, but patient care is done by nurses," she added.

'SECOND-CLASS STATUS'?

Michael H. Miller, an associate professor of sociology in nursing at Vanderbilt University School of Nursing, recently charged in a Hospitals article that "the exclusion of nurses from PSRO membership represents an attempt by physicians to constrain the growing power of nursing," a move that implies "a second-class status for nursing."

Citing the power the PSRO law gives to physicians to accept or reject nursing standards of practice, Miller says, "The PSRO law, as presently written, may herald the demise of the expanded role of the nurses as well as professional nursing as we know it today."

Most nurses contacted by PSRO Update felt Miller may have been overstating the case to make a point, but several agreed there was a point to be made. Miller's predictions are "only a possibility, not a probability," said Betty Erlandson, R.N. of the ANA PSRO project. "Of course," she said, "no reasonable group of physicians would presume to pass on nursing standards."

In the long run, nurses hope to be involved at all levels of PSRO, and the ANA is assuming that actions of PSRO advisory committees "will have some impact," Erlandson said. Nursing has moved ahead "faster than other disciplines" in preparing for participation in PSRO.

The wording of the law gives doctors more power and responsibility than they probably want, Muriel Poulin believes. "If the law should be interpreted literally, with physicians held responsible for the care given by all the other health-care practitioners, the potential for malpractice suits alone would be enormous."

Erlandson echoed the sentiments of the other nurses when she said, "Only the members of a professional group can really assess, evaluate or set standards for their own profession."

However, some nurses differed in their view of the importance of advisory committees, which will include nurses. Erlandson feels there is no reason to assume all PSROs will be restrictive in their interpretation of the advisory committee role, but McCourt says, "We (in Massachusetts) don't see advisory committees as being where it's at."

NURSES PARTICIPATING

"Nurses are very vigorously performing nursing audits," Ellis said--partly to comply with Joint Commission on Accreditation of Hospitals requirements for audits, but also "in anticipation that they will be asked to participate in quality-assurance programs by a PSRO."

Noting that there are not enough operational PSROs for anyone to know how extensively nurses will be involved, Erlandson expressed optimism about the outlook for interdisciplinary cooperation in peer review.■

Transposing audit system from the hospital to the ambulatory setting

(Continued from pg. 8)

trols in the two years we have been doing it. For example, we can now discover where a physician fails to give instructions to a patient's family after emergency treatment, because the family must sign a receipt for a coupon on which the instructions are written, an item on the audit.

And then, our audit shows the occasional examples of a physician's forgetting to write the instructions in plain English. A heart-to-heart talk with the physician can change this.

Good audits are always a difficult, and sometimes an unpleasant, exercise. What is acceptable care to one physician may be an abomination to another. Only by setting clear objective criteria can the retrieval of data and analysis of patterns be farmed out to technicians, and only by coding ambulatory records by diagnosis can retrospective audits of any kind be introduced into outpatient services. The coding and retrieval are easy to do once an encounter sheet is devised. After that, it is a matter of letting the established system work.■

Harris C. Faigel, M.D.
Director of Adolescent Medicine
Kennedy Memorial Hospital for Children
Brighton, Mass.

FORUM

Transposing audit system from the hospital to the ambulatory setting

(The following view by Harris C. Faigel, M.D., advances the point that audit of ambulatory care is less difficult than it appears, and that it ought to be made a regular part of procedures in emergency rooms.)

Retrospective audit techniques have been devised because of the need for peer review, and the need to assess and control the cost and quality of care of patients in hospitals.

In the ambulatory setting--private offices, clinics or emergency departments--techniques that have been developed for auditing care of inpatients have to be modified for auditing care of nonhospitalized patients.

Audit systems work on inpatient records because all records are maintained by the hospital, because there are corroborative data in the record and because medical record librarians code every diagnosis. All charts with the same diagnosis are recorded on master lists, making them retrievable by diagnosis so that many patients with the same disease can be compared to the standard at one time. Furthermore, the outcome of treatment is also recorded in the chart. People remain in the hospital long enough for someone to describe the condition later and for the results to be known.

AMBULATORY DIFFICULTIES

On the other hand, ambulatory care faces problems not encountered by the hospital: diagnoses are never coded and chart names or numbers are never recorded on master lists (even in the best of record libraries). Thus, retrieval by diagnosis and comparisons of care and outcome are simply impossible.

Beyond this, even if every record were suddenly to be coded by diganosis, patients may not be observed long enough for the outcome to be known. Many visits involve a single encounter because no followup is necessary. Other visits are single encounters because of the place or time of day (the emergency department, a physician covering for a colleague, etc.) because the patient is referred elsewhere or because the patient fails to return for a followup appointment.

Despite these problems, ambulatory records can be audited retrospectively for outcome. Only the common diagnoses need to be audited regularly, since these will, like inpatient records, be representative of a physician's performance. Furthermore, good quality ambulatory care can be defined and charts can be checked to see that the appropriate steps are carried out for certain diagnostic categories that do not require followup or referral visits--in some instances, even a second visit is an undesirable outcome.

CODING OF CHARTS

To audit retrospectively for outcome by diagnosis--that is, to compare a set of ambulatory records containing the same diagnosis with a list of criteria that define that diagnosis and its care and outcome--is not difficult in a setting where retrospective audit is already being done. It requires first the coding of charts by diagnosis, and this is not an insurmountable task. One can devise an encounter sheet listing the 25, 50 or 100 most common diagnoses in that office, clinic or emergency department with assigned code numbers.

At each visit, the patient's identification is entered on a new coded encounter sheet, and the appropriate diagnosis checked off. The encounter sheets themselves are filed by code numbers because it is quicker than transcribing the data onto master lists. Since this process requires more storage space, transcription is reasonable alternative. However it is done, encounter sheets solve the retrieval problem.

Only diagnoses that have a regular plan for followup need to be audited. In our emergency department, every child who has a throat culture positive for beta-hemolytic strep is brought back for followup; every child who has otitis media or a laceration sutured is also checked and the outcome recorded. Fractures and ligamentous injuries are generally treated in the hospital's orthopedic department, and regular notes are made of telephone contacts made in lieu of followup office visits.

Thus, diagnostic and followup data are available in the chart for many diseases, making retrospective outcome audit possible. In other cases, such as cold and roseola and poison ivy, return visits are not necessary, although explicit written instructions must be written on the charts, and these records can be audited too.

Auditing ambulatory care in our hospital has produced a general tightening up on con-

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